STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
233 RICHMOND STREET
PROVIDENCE, RHODE ISLAND 02903

ORDER AND DECISION (OHIC-2006-4)

Filing by Blue Cross & Blue Shield of Rhode Island for New Non-Group Subscription Rates for Plan 65 Medigap Plans A, B and C, New Non-Group Subscription Rates for Plan 65 Select Plans B and C, and New Non-Group Subscription Rates for Plan 65 Select Plan L (Filed September 29, 2006)

This Order and Decision is issued in response to the September 29, 2006 request of Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for approval of a rate increase of 9.9% for the Plan 65 Medigap Plans A, B and C and Plan 65 Select Plan C, a rate increase of 5.42% for the Plan 65 Medigap Plan B and approval of an initial rate for the new Plan 65 Select Plan L product (hereinafter "the Filing"). After full consideration of the Filing, the position papers submitted by Blue Cross and the Attorney General, recommendations submitted by my staff and an independent actuary, testimony offered at two public meetings regarding the Filing, written comments received by Plan 65 members and the applicable statutes and regulations, the rates requested by Blue Cross in the Filing are approved with the following modifications:

1. Blue Cross must apply a 0% physician fee schedule conversion factor, and
2. Blue Cross may not charge the cost of the Age-In discount to new or existing Plan 65 members.

Blue Cross must recalculate its Plan 65 rates consistent with this Order and Decision. To the extent that these modifications reduce the rates below the rates submitted by Blue Cross (i.e., the 9.9% capped rates or the 5.42% for Plan B), Blue Cross must use the new recalculated rates. To the extent that these modifications do not reduce the rates below the rates submitted by Blue Cross, the rates submitted by Blue Cross shall be applied.

I. THE REQUESTED RATE INCREASE

The Filing

The Filing requested increases in premiums charged to subscribers who are Medicare beneficiaries and members of non-group Plan 65 Medicare supplement ("Medigap") Plans A, B and C and Plan 65 Medicare supplement Select ("Select") Plans B and C. The Filing also requested approval of initial rates for Select Plan L.

The Blue Cross Plan 65 policies provide Medicare supplement health insurance coverage. These policies help pay for some of the health care costs that original Medicare does not cover.[1] Blue Cross offers four types of Medicare supplement policies: Plans A, B and C, with a Select variation of the Medigap B, C and L plans.[2]

There are approximately 21,300 members of Blue Cross' non-group Plan 65 products. The enrollment by product is approximately as follows:

PLAN	APPROXIMATE ENROLLMENT
Medigap Plan A	133
Medigap Plan B	139
Medigap Select Plan B	142
Medigap Plan C	15,596
Medigap Select Plan C	5,367
TOTAL	**21,377**

It should be noted that Medigap Plan C and Select Plan C together have nearly 21,000 members and approximately 98% of the membership.

The Plan 65 rates currently in effect were approved by Office of the Health Insurance Commissioner ("OHIC") on October 25, 2005. The proposed rates in the Filing will be

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[1] General information about Medicare supplement policies is available from the federal government at http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf.

[2] Plan 65 Select plans offer the same coverage as regular Plan 65 Medigap plans but at a lower cost. The lower cost is made possible by restricting certain covered services to a network of participating hospitals and doctors.

applicable to billing cycle rate years commencing February 1, 2007, March 1, 2007 and April 1, 2006. Rates for the new Medigap Select Plan L will be effective beginning February 1, 2007.

The proposed rate increases will change the Plan 65 Medigap rates for existing subscribers as follows:[3]

PLAN	PRESENT MONTHLY RATE	PROPOSED MONTHLY RATE	PERCENTAGE INCREASE
Plan A-Discount	$96.32	$105.86	9.9%
Plan A-Base	$107.02	$117.61	9.9%
Plan A-Surcharge	$128.42	$141.13	9.9%
Plan B	$101.47	$111.52	9.9%
Plan C-Discount	$150.04	$164.89	9.9%
Plan C-Base	$166.71	$183.21	9.9%
Plan C-Surcharge	$200.05	$219.85	9.9%

The proposed increases will change the Plan 65 Select rates for existing subscribers as follows:

PLAN	PRESENT MONTHLY RATE	PROPOSED MONTHLY RATE	PERCENTAGE INCREASE
Select Plan B-Discount	$93.48	$98.55	5.42%
Select Plan B-Standard	$113.64	$119.80	5.42%
Select Plan C-Discount	$104.28	$114.60	9.9%
Select Plan C-Standard	$142.11	$156.18	9.9%

The proposed initial rate for Select Plan L is as follows:

PLAN	PROPOSED MONTHLY RATE
Select Plan L	$102.38

[3] The Discount Rates for Plans A and C are applicable to subscribers who enrolled prior to November 1, 1998 and within six months of their first eligibility for Medicare Part B as their primary insurer. The Base Rates for Medigap Plans A and C are applicable to all new enrollees, those subscribers who enrolled on or after November 1, 1998, and those subscribers who enrolled prior to November 1, 1998 and between six months and five years of first eligibility for Medicare Part B as their primary insurer. The Surcharge Rates for Medigap Plans A and C are applicable to subscribers who enrolled prior to November 1, 1998 and after more than five years of first eligibility for Medicare Part B as their primary insurer. Blue Cross discontinued the use of "point-of-entry" rating for Medigap Plans A and C for all new subscribers enrolling after November 1, 1998. Subscribers who had "point-of-entry" rates as of November 1, 1998 continue to have the Discount and Surcharge Rates since this rating system was intended to be in effect for the lifetime of the subscriber.

In addition, Blue Cross has proposed an "Age-In" rate for new members:

PLAN	PROPOSED MONTHLY RATE
Plan A	$82.33
Plan C	$128.25
Select Plan C	$80.22
Select Plan L	$71.67

Blue Cross asserts that its actuarial analysis supports rate increases ranging from 11.07% (Plan A) to 14.86% (Select Plan C) for all but the Select Plan B products (which requires only a 5.42% increase).[4] In the Filing, Blue Cross capped these "required rates" at 9.9%.

In addition to capping its required rates, Blue Cross alleges that it has addressed its requirements for efforts to improve the affordability of it products, as detailed in Section II below through the use of an Age-In Credit Program, the introduction of Select Plan L, changes to product eligibility guidelines and "other initiatives".

Age-In Credit

The Age-In Credit program is designed to increase Plan 65 enrollment and attract younger, healthier members. The credit is available to new Plan 65 members who enroll in Plan 65 within six months of becoming eligible for Medicare Part B. These new members will receive a 30% discount in their first year as a Plan 65 member, a 20% discount the second year and a 10% discount the third year. After the third year, the member will pay the usual, non-discounted rate.

Blue Cross expects this discount to encourage enrollment of younger, healthier members in the coming years. These enrollments are expected to have a favorable effect on the claims experience of the overall Plan 65 membership, since Blue Cross has found that these younger

[4] The resulting average required rate increase for these products is 12.4%.

members have 35% fewer claims than the average Plan 65 member. Blue Cross believes that, over time, an increase in the number of new, younger members will moderate rate increases.

The cost of the Age-In discount is, however, shifted to existing Plan 65 members. Blue Cross currently enrolls approximately 55 new subscribers each month who would be eligible for this program. Blue Cross has determined the amount of the premium discount it expects for those 55 people and has spread that amount over the entire block of business. This has resulted in approximately a 0.4% charge to Medigap customers and a 1% charge to Select customers.[5] However, to the extent that the Age-In program results in additional new members beyond the number of members Blue Cross has been experiencing, those members will be able to receive the discounts Blue Cross has proposed, and Blue Cross has not built in a charge to recover any amounts relative to those new members.

Medigap Select Plan L

Select Plan L is a new product offering in Blue Cross' Plan 65 line of products.[6] Select Plan L has a lower premium than the base rate for the other Medigap Select products. That lower premium results from higher cost sharing.[7] The rates for Select Plan L were developed by applying a benefit richness factor and a claims reduction factor to the pure premium calculation for the Medigap Select Plan C product.

Blue Cross asserts that the lower premium of Select Plan L will encourage enrollment, particularly among healthier enrollees, and the higher cost sharing component of the product will

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[5] Medigap Select customers are charged more because proportionately more of the new enrollees are enrollees in the Select plans.

[6] All Medigap Product designs are pre-determined by the Federal Government. Insurers may offer some or all of them.

[7] There is, however, an annual out-of-pocket limit of $2000.

encourage more appropriate utilization of medical services. Blue Cross believes that these factors will help moderate future rate increases.

Changes in Product Eligibility

Blue Cross Plan 65 members who want to switch from one product to another must pass medical underwriting and may only switch plans during the open enrollment period—from November 1st through November 30th of each year. In its filing, Blue Cross proposes to make the lower cost Medigap Plan A and Select Plans C and L available to Plan 65 members at any time during the year and without a medical screen. According to Blue Cross, this would allow current Plan 65 members to take advantage of network savings without impacting benefits levels (e.g., by switching from Medigap Plan C to Select Plan C) or to move to a less rich plan. Blue Cross does not anticipate that this will affect rates.

In addition, Blue Cross is proposing that Medigap Plan A and Select Plan L be available for all new members, including those who do not pass a medical screen, and that these products be available all year long—thereby eliminating the open enrollment period for these products.

Other initiatives

Blue Cross also notes in the Filing that it has undertaken multiple initiatives "aimed at improving the quality and efficiency of the healthcare delivery system in Rhode Island . . . ." The list of these initiatives includes promoting the adoption and implementation of electronic health records, creating a pilot project to support the "chronic care model" of medical practice for chronic disease, providing incentives for physicians to better understand the wishes of their patients during end-of-life treatment and providing incentives for primary care physicians to increase the availability of "after hours" care as an alternative to the hospital emergency room. Blue Cross notes, however, that the impact of these initiatives on Plan 65 is not quantifiable.

II. LEGAL STANDARDS

Jurisdiction

The OHIC has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. No hearing was required for the Filing and no hearing was held.[8]

Standard of Review

The rates requested by Blue Cross must be "consistent with the proper conduct of the applicant's business and with the interest of the public . . . ."[9] The OHIC may approve, disapprove, or modify the rates proposed by Blue Cross.[10]

In 2004 the Rhode Island General Assembly established the meaning of "proper conduct of the applicant's business" with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*[11] They decreed that Blue Cross' mission includes providing "affordable and accessible health insurance to insureds"[12] and "affordable and accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals."[13] The Board of Directors was specifically charged with "ensuring that the corporation effectively carries out the charitable mission for which it was incorporated . . . ."[14] Under the new law, Blue Cross must

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[8] Because no hearing was scheduled, two public meetings were held on Wednesday, November 29, 2006 at 10:00 a.m. and at 5:00 p.m. to solicit public input on the Filing. Only a few people came to the meetings. Comments were offered only by the Department of Elderly Affairs, Rhode Island Senior Action Network and the Gray Panthers of Rhode Island. These groups opposed the rates requested by Blue Cross.

[9] R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

[10] Id.

[11] See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd, Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

[12] R.I. Gen. Laws § 27-19.2-3(1).

[13] R.I. Gen. Laws § 27-19.2-3(5).

[14] R.I. Gen. Laws § 27-19.2-4(b).

also "employ pricing strategies that enhance the affordability of health care coverage . . . ."[15] These legislative directives make clear that the "proper conduct of the applicant's business" is no longer left solely to the management's discretion unless that discretion is exercised to provide "affordable" and "accessible" health insurance.[16]

Affordability

Accordingly, there can be no doubt that the General Assembly made the issue of "affordability" central to Blue Cross' operations and product offerings. The plain language of the above-referenced statutes makes several things clear. First, the General Assembly intended for Blue Cross to take ongoing affirmative action to address the affordability of its products. Reliance on the *status quo*, its existing products, or its current methods of operation are not options for Blue Cross. Second, the General Assembly made affordability a cornerstone of Blue Cross' operations by expressly mandating that Blue Cross' mission include a pledge that it would provide affordable health insurance coverage. Third, the General Assembly required Blue Cross to employ "strategies" to enhance the affordability of its products. In other words, Blue Cross has to employ multiple approaches to the affordability issue. The General Assembly's use of the word "strategies," rather than the singular "strategy," eliminates the use of a single approach to affordability as an option. Finally, Blue Cross' approach to affordability must be "comprehensive." Blue Cross cannot confine its affordability strategies to a single product, a single segment of its market, or single approach. These standards were applied to Blue Cross in

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[15] R.I. Gen. Laws § 27-19.2-10(3).

[16] See *In re Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR*, DBR No. 04-I-0144 (Nov. 23, 2004), *aff'd, Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 (R.I. Super. 2005).

the context of a Plan 65 filing in 2005.[17]

Although the General Assembly required Blue Cross to address affordability in a comprehensive manner, the statutory terms "affordable" and "affordability" were left undefined. Construction of those terms is left to the OHIC.[18] In the 2005 Plan 65 proceeding, the OHIC provided Blue Cross with guidance on the issue of affordability:

> **Long Term Goal:**
> - Stable, predictable rates for high quality cost efficient products
>
> **Current Bases for Assessing Affordability:**
> - Rate of trends
> - Price comparison to other market rates for similar products
> - Acknowledge effect of income on what people are able to pay for insurance (i.e., it is harder for the poor to afford health insurance)
> - Pricing Strategies to Enhance Affordability
>   - *Good efforts absent government mandate*
>   - *Spectrum of product choices*
>   - *Specific benefit designs & cost sharing arrangements*
>   - *Control over administrative costs, including system-wide costs*
>
> **Principles to Evaluate Pricing Strategies to Enhance Affordability**
> - Offer products that address the underlying cost of healthcare by creating appropriate incentives for consumers, employers and providers. These incentives will drive efficiency in the following areas:
>   - *Focus on primary care, prevention and wellness*
>   - *Active management of the chronically ill population*
>   - *Use of the least cost, most appropriate setting*
>   - *Use of evidence based, quality care*
> - Provider payment to enhance cost effective utilization of appropriate services
> - Support the product offerings with a simple and cost effective administrative process
> - Promote broad public conversation on trade-offs and cost effects

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[17] See *In re Blue Cross & Blue Shield of Rhode Island Filing for New Non-Group Subscription Rates for Plan 65 Medigap Plans A, B and C and New Non-Group Subscription Rates for Plan 65 Select Plans B and C*, HIC No. 05-RH-01 (Oct. 28, 2005) [hereinafter "Medigap 2005"].

[18] See *Blue Cross & Blue Shield of R.I. v. McConaghy*, 2005 R.I. Super. LEXIS 107 at *19 (R.I. Super. 2005).

of medical choices
- Allow for an appropriate contribution to reserves

Constraints on Affordability Efforts

- State and federal requirements (e.g., state mandates, federal laws)
- Costs of medical services over which plans have limited control
- Health plan solvency requirements
- Prevailing financing system in United States (i.e., third-party payor system)[19]

These guidelines provide a framework within which Blue Cross' efforts regarding affordability can be assessed.

Administrative Costs

In addition, the 2004 legislation empowered the OHIC to review each administrative cost of Blue Cross and determine the reasonableness of such costs.[20] Blue Cross, therefore, has the burden of providing detailed information and justification for all administrative expenses in its rate filings if it is to satisfy this requirement.

Discharge of the OHIC's Powers and Duties

Finally, the General Assembly mandated that the OHIC discharge its powers and duties to:

(a) Guard the solvency of health insurers;

(b) Protect the interests of consumers;

(c) Encourage fair treatment of health care providers;

(d) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and

(e) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the

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[19] See Medigap 2005 at 13-14.

[20] R.I. Gen. Laws § 42-14.5-3(b) ("[T]he commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs.").

welfare of the public through overall efficiency, improved health care quality, and appropriate access.[21]

Accordingly, the OHIC's decision in this matter must take these factors into account.

III. ANALYSIS OF THE FILING

Position of the Attorney General

The Attorney General (the "AG") was invited to participate in the analysis of the Filing. The AG reviewed the filing and was allowed to request additional data from Blue Cross with respect to the Filing. As a result of its analysis, the AG submitted alternative rate calculations. In its alternative rate calculations, the AG disagreed with the rates requested by Blue Cross and instead recommends the following rate changes for the Plan 65 products:

PLAN	PRESENT MONTHLY RATE	BLUE CROSS' PROPOSED % MONTHLY RATE INCREASE	AG's PROPOSED % MONTHLY RATE INCREASE	DIFFERENCE BETWEEN BLUE CROSS AND AG PROPOSED RATES
Plan A-Discount	$96.32	9.9%	3.4%	-6.5%
Plan A-Base	$107.02	9.9%	3.4%	-6.5%
Plan A-Surcharge	$128.42	9.9%	3.4%	-6.5%
Plan B	$101.47	9.9%	7.8%	-2.1%
Plan C-Discount	$150.04	9.9%	7.8%	-2.1
Plan C-Base	$166.71	9.9%	7.8%	-2.1
Plan C-Surcharge	$200.05	9.9%	7.8%	-2.1

[21] R.I. Gen. Laws § 42-14.5-2.

The increase proposed by the AG would result in the following Plan 65 Medigap Select rates:

PLAN	PRESENT MONTHLY RATE	BLUE CROSS' PROPOSED % MONTHLY RATE INCREASE	AG's PROPOSED % MONTHLY RATE INCREASE	DIFFERENCE BETWEEN BLUE CROSS AND AG PROPOSED RATES
Select Plan B-Discount	$93.48	5.42%	-9.3%	-14.72%
Select Plan B-Standard	$113.64	5.42%	-9.3%	-14.72%
Select Plan C-Discount	$104.28	9.9%	0.9%	-9.0%
Select Plan C-Standard	$142.11	9.9%	0.9%	-9.0%

The AG's proposed initial rate for Plan 65 Medigap Select Plan L is as follows:

PLAN	BLUE CROSS' PROPOSED MONTHLY RATE	AG's PROPOSED MONTHLY RATE	DIFFERENCE BETWEEN BLUE CROSS AND AG PROPOSED RATES
Select Plan L	$102.38	$87.64	-$14.74

The AG explains that its lower rates calculations result from the Blue Cross overstating its claim cost projections for 2007 and 2008, Blue Cross' use of an unfair per contract method of allocating administrative costs, and Blue Cross' recovery of the costs of the Age-In program from existing Plan 65 members.

Overstated Projections

The AG's analysis of Blue Cross' expected claims costs differs from Blue Cross' in two major respects. First, while Blue Cross relies on a complete year of actual claims data from 2005 to calculate projected claims costs for 2007 and 2008, the AG uses the 2005 data as well as projected 2006 costs. The projected 2006 costs are based on actual claims data for the first six months of 2006 and estimated claims data for the remainder of 2006. It is the use of the 2006 projected costs that appears to create the greatest difference between the AG's proposed rates and Blue Cross' proposed rates.

Second, the AG argues that Blue Cross' use of a physician fee schedule conversion factor of 1.5% is too high, given that the Centers for Medicare and Medicaid Services ("CMS") recently set this factor at -5.0%. Blue Cross arrived at the 1.5% figure by applying the final physician fee schedule conversion factor applicable to 2004 and 2005. Blue Cross arrived at this figure by assuming that Congress will override CMS' current -5.0% conversion factor. Congress has done so for 2003 through 2006. For each of those years, CMS initially reduced payments to physicians. Ultimately, however, each of the CMS reductions was reversed by Congress and the physician fee schedule conversion factor was either increased from the previous year or was held steady:

YEAR	CMS REDUCTION	CONGRESSIONAL OVERRIDE
2003	-4.4%	1.6%
2004	-4.5%	1.5%
2005	-4.5%	1.5%
2006	-4.5%	0%

The AG argues that Blue Cross' use of the 1.5% factor is too high given CMS' announcement of a -5% factor.

Blue Cross' Per Contract Administrative Cost Allocation Method

The AG also takes issue with the method used by Blue Cross to allocate administrative costs to Plan 65 members. Blue Cross uses a per contract method. In other words, Plan 65 administrative costs are allocated evenly among Plan 65 members, regardless of product chosen or premium dollars paid. This results in $19.73 monthly allocation to each Plan 65 member. This method is consistent with prior Blue Cross practices and has been approved in prior filings. The AG suggests that this practice is unfair. First, the AG notes that common industry practice is to allocate such costs more equitably, so that costs are distributed partly on a contract basis and partly on a premium dollar basis.

In its alternative rate calculations, the AG calculated the difference in rates if Blue Cross allocated 50% of its administrative costs on a per contract basis and 50% of those costs on a per premium dollar basis.[22] The AG determined that this method would result in an increase in .4% for Medigap Plan C enrollees and a decrease of 1.4% to 4.3% for all other enrollees.

Blue Cross' Recovery of the Costs of the Age-In Program From Existing Members

The AG asserts that Blue Cross has overstated the costs of the Age-In program and argues that Blue Cross' method of allocating the costs of the Age-In program is unfair because Blue Cross is shifting the costs of a business investment to its members. The AG does not, however, object to the Age-In program itself. In fact, the AG suggests that the proposed "steepness" of the program (3 years) should be moderated by extending the discount over five years. The proposed discounts would be 30% in the first year, followed by discounts of 20%, 15%, 10% and 5% in years 2 through 5, with no discount in years 6 and beyond.

III. ANALYSIS

Trend Factors

The trends used by Blue Cross in its Plan 65 rate filing were reviewed by OHIC's consulting actuary, Mr. Charles C. DeWeese, FSA, MAAA. Blue Cross used standard methods and Mr. DeWeese found the results reasonable. Blue Cross has based its beginning cost value on 2005 experience, including claims paid through June 2006. Blue Cross then projected the 2005 claims to 2006, 2007 and 2008. Blue Cross's methods incorporate separate analysis of benefit changes mandated by Medicare and expected utilization changes. Blue Cross therefore projects each benefit element separately. However, in aggregate, the average trends they used for all

[22] Under this alternative calculation, enrollees would be charged a flat rate of $9.86 per contract, plus 5.76% of premium.

benefits combined were:

- 5.7% for Select Plans and 5.8% for Medigap plans to project from 2005 to 2006
- 6.6% annually for Select Plans and 6.5% annually for Medigap plans to project from 2006 to 2007 and from 2007 to 2008[23]

The AG's actuary has projected costs using partial year 2006 as a base, and has assumed trends from that point forward at 4% for Select plans and 7% for Medigap plans for both 2006 to 2007 and 2007 to 2008.

Mr. DeWeese disagrees with the AG's actuary's recommendation that Blue Cross base its rate increase on trends observed in the 2006 partial year of experience. He finds that Blue Cross's argument for using a stable method from year to year to be compelling. Mr. DeWeese notes that it is difficult for all parties to comprehend and analyze all the elements of a filing like the Plan 65 filing. Thus, it is preferable to settle on an effective methodology and make changes only when necessary, rather than to try new methods, particularly if those methods are designed to reach a certain result. Thus, while the AG's method would result in a lower rate increase calculation this year, it would be a more volatile method over time, creating more difficulty in reviewing future filings, and creating the potential for large increases in the future.

In addition, Mr. DeWeese notes that Blue Cross' method of analyzing each element of the benefit separately is reasonable and is consistent with standard actuarial practice he has observed in other states. The method provides for full understanding of how each element of the benefit program affects the rate increase, and allows for adequate review of each element.

Finally, Mr. DeWeese notes that Blue Cross has presented in its response compelling evidence that the partial year 2006 experience relied on by the AG's expert is biased downwards

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[23] Moreover, according to an independently compiled trend analysis report submitted by Blue Cross, these trends are close to the median trend for the national Medigap market.

by events of the first part of the year.

I accept Mr. DeWeese's analysis and find that Blue Cross' trend projections are reasonable.

Physician Fee Schedule Conversion Factor

In November, CMS announced a 5.0% decrease for the physician fee schedule conversion factor for next year. CMS has announced fee decreases of comparable magnitude in each of the past four years. Congress, however, has overridden each of these decreases. The result has been fee levels that have either stayed flat or increased by up to 1.6%. Based on the pattern of Congressional overrides, Blue Cross assumed a 1.5% increase for the physician fee schedule conversion factor in each of the next two years.

On December 9, 2006, the House of Representatives and the Senate agreed to H.R. 6111, the "Tax Relief and Health Care Act of 2006" (the "TRHCA"). The President is expected to sign the bill into law. The TRHCA rolls back the previously announced a 5.0% decrease in the 2007 physician fee schedule conversion factor. Thus, the new factor for 2007 is 0%. This is the factor that shall be applied to the Plan 65 rates in Blue Cross' Filing.[24]

Blue Cross' Per Contract Administrative Cost Allocation Method

As noted above, Blue Cross charges administrative fees on a per subscriber per month basis. This is consistent with how Blue Cross charges administrative fees to its other lines of business, and consistent with how Blue Cross analyzes its expenses generally. Blue Cross has described the nature of its claims processing, which is not affected by the relative benefits provided for the various Plan 65 plans. Instead, Blue Cross uses approximately the same effort

[24] Although Congress also authorized an additional 1.5% increase in payments for physicians who report data on specified quality measures beginning July 2007, the OHIC cannot determine with any certainty how many Rhode Island physicians will participate in this program and how this participation will impact Plan 65 rates. Therefore, Blue Cross may not add this 1.5% factor into its Plan 65 rate calculations.

to pay claims under any of the Plan 65 plans.

On the other hand, it is common for insurers to allocate administrative fees on either a percentage of premium or a blended basis. For example, BCBSMA charges expenses to its Medex business on a percent of premium basis. The AG has proposed that Blue Cross change to an administrative basis under which half the costs are charged on a per subscriber basis and half on a percent of premium basis. The AG has calculated correctly that the lower cost plans would have lower rate need on that basis, while the higher cost Medigap Plan C would have a slightly higher rate increase.

The AG's method seems attractive, in that it can deliver rate decreases ranging from 1.6% to 3.9% for some of the existing plans, and 4.3% for the proposed new Select Plan L, while only requiring a 0.5% increase for Medigap Plan C. However, that is because Medigap A and B and Select Plan B only have approximately 140 members each, while Medigap Plan C has 15,000 members. In addition, Medigap Plan B and Select Plan B are now closed blocks and can be expected to get even smaller. It therefore seems unproductive to require changes in the way Blue Cross operates that are not driven by actual costs, in order to benefit a small percentage of the Plan 65 population.

Blue Cross' Recovery of the Costs of the Age-In Program From Existing Members

While this program may be worthwhile, neither I nor the AG are convinced that existing Plan 65 members should fully bear the costs associated with this program, especially since no benefits are immediately expected. Therefore, the costs associated with the Age-In program may not be passed on to existing Plan 65 members.

In addition, the AG has proposed that the new program be extended to a five-year period rather than a three-year period. In the opinion of Mr. DeWeese, the greatest value to be derived

from this program will be seen in year one, when people are enrolled. After that, diminishing returns for each subsequent year of discounts would be expected, since the members would already be enrolled. Mr. DeWeese does not think it would be worthwhile to extend this program to five years, and I agree.

Affordability Issues Address By Blue Cross[25]

Spectrum of product choices

Blue Cross offers several different products for Medicare eligible members, including a new Select L product and several Medicare Advantage products.

Control over administrative costs, including system-wide costs

Blue Cross appears to have maintained reasonable control over the administrative costs allocated to Plan 65 products. In response to Blue Cross' Filing, AG Request 1-03 asked why the 2006 Plan 65 expense projection had increased to $6.2 million from the projection of $5.4 million Blue Cross made for 2006 in the prior Plan 65 filing. Blue Cross responded by providing a summary, including explanations of the major variances. There are three categories of expense that account for the entire difference:

- Blue Cross had anticipated that Perot fees would be less in 2006 than in 2005 because of the drop in enrollment. However, they have found that the jobs run by Perot are more of a fixed cost than a variable cost nature, and fees are $340,000 higher in the new projection than they were in the old one.
- Medicare crossover fees are higher than were originally expected for 2006 because of a delay in invoicing for prior years that led to projection from a base that was too low. The increase reflected in the expense projection is $170,000.

[25] The affordability factors will be discussed only to the extent they have not already been addressed elsewhere in this Order and Decision.

- Blue Cross incurred $370,000 of unanticipated systems change need to comply with CMS changes in how crossover claims are processed.

Blue Cross's expense projection for 2007 is actually slightly lower than for 2006, because they do not anticipate any additional systems changes in 2007, and the crossover fees problem is now behind them. This offsets other changes in expenses, including inflation. On balance, Blue Cross' 2006 expense projection appears to be reasonable.

It is imperative to note, however, that if Blue Cross does not find ways to increase Plan 65 enrollment, the product's administrative costs may become too much of a burden on members in the future.

Specific benefit designs and cost sharing arrangements

Blue Cross has little control over Plan 65 benefit design. However, there are a number of different Medigap plans for Blue Cross to offer. This year, they are offering a new product, Select Plan L.

State and federal requirements

Federal Medicare requirements place some limits on Blue Cross' ability to directly address the costs of Plan 65 claims. Nevertheless, evidence offered in the last Plan 65 rate filing made clear that system-wide efforts to reduce claim costs could help reduce Plan 65 claims costs. Blue Cross' failure to address such system-wide efforts in the Filing is discussed below.

The Affordability Factors Not Addressed by Blue Cross

Blue Cross did not adequately address the remainder of the affordability guidelines. Those guidelines included: price comparison to other market rates for similar products; taking steps to focus subscribers and providers on primary care, prevention and wellness; actively managing its chronically ill membership, including those in Plan 65; encouraging use of the least

cost, most appropriate setting; encouraging use of evidence based, quality care; promoting provider payments to enhance cost effective utilization of appropriate services; promoting a broad public conversation on trade-offs and cost effects of medical choices; and costs of medical services over which Blue Cross has limited control.

As was the case with the 2005 Plan 65 filing, Blue Cross has failed to fully address the affordability guidelines. In particular, Blue Cross has failed to address the issue of system-wide costs. This is particularly troublesome. Blue Cross recently developed an affordability plan in response to the Order and Decision in the 2005 Plan 65 case. After that plan was developed, the Office directly requested that Blue Cross provide detailed information and empirical analysis of its ongoing, system-wide affordability efforts in its rate filings, including this one.[26] Blue Cross has failed to do so. Indeed, Blue Cross' discussion of system-wide affordability efforts is limited to a few lines in one of the documents included in the Filing. This is simply not acceptable. Blue Cross cannot take a "siloed" approach to affordability, addressing only the affordability issues it believes are relevant to a particular product. Effective immediately, Blue Cross will be required to submit a detailed and comprehensive affordability report with any rate or trend filing it makes for its products in the Medicare supplement, direct pay, large group and small group market. The report, to be compiled annually and updated with any filing, must be current, comprehensive, and detailed. The report must provide an overview and assessment of company-wide strategies to improve both the efficiency and effectiveness of the health system in which Blue Cross operates and the affordability of its products, consistent with the guidance offered by this office, Blue Cross's charter and its leadership role in the health care community. The report

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[26] See, e.g., "Order and Decision," Medigap 2005 (August 28, 2006). In addition, this message was conveyed to Blue Cross personnel at several meetings, including a meeting held immediately prior to the filing in this case.

must also provide current estimates or projections as to the expected results of affordability initiatives or must provide some other explanation as to why such initiatives are (or will be) undertaken. Finally, the report must assess expense trends by service category overall and for the relevant Blue Cross product in light of those efforts. Failure to do so may result in a denial of the rates or trends submitted for approval, or in cases where approval is not typically issued in response to a particular filing, an administrative penalty may be issued.

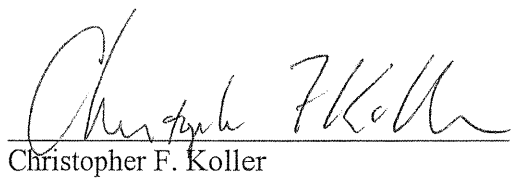
VI. CONCLUSION

The following chart sets out our estimates of the rate increases for Blue Cross' Plan 65 products based on an application of the 0% physician fee schedule conversion factor and an elimination of costs to Plan 65 members associated with the Age-In program:

Plan	Required Rate Increase or Required Rate	Rate Increase Requested	0% Conversion Factor and No Age-In Program Recovery from Members	Rate Increase/Rate Approved
Medigap Plan A	11.1%	9.9%	9.7%	9.7%
Medigap Plan B	12.2%	9.9%	11.2%	9.9%
Medigap Plan C	12.2%	9.9%	11.2%	9.9%
Select Plan B	5.4%	5.4%	3.5%	3.5%
Select Plan C	14.9%	9.9%	13.1%	9.9%
Select Plan L	$102.38	--	$101.74	$101.74

Within the next five days, Blue Cross must recalculate its Plan 65 rates consistent with this Order and Decision. If those recalculated rates are not consistent with the rates set out in the above table, Blue Cross must submit those recalculated rates to this Office.

ENTERED AS AN ADMINISTRATIVE ORDER OF THE OFFICE OF THE OFFICE OF HEALTH INSURANCE COMMISSIONER THIS 14th DAY OF DECEMBER, 2006.



Christopher F. Koller
Commissioner
Office of the Health Insurance Commissioner

THIS DECISION CONSTITUTES A FINAL DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS DECISION MAY BE APPEALED UNDER THE ADMINISTRATIVE PROCEDURES ACT, RI GEN. LAWS § 42-23-1 *ET SEQ.*, TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.